State of Nebraska
Advance Directives/Power of Attorney for Health Care

I _____ (your name)

residing at _____

being of sound mind and having examined the potential consequences of this document, hereby make the following provisions for my health care, custody and medical treatment:

1. Appointment of Agent. I hereby appoint as my attorney-in-fact (Agent) for the purpose of making decisions regarding my care and medical treatment, the following individual:

Name of Agent _____

Agent's address_____

Agent's telephone number _____

I appoint the following person as my Successor Agent if my Agent is unable or unwilling to serve as my Agent:

Name of Successor Agent _____

Successor Agent's address _____

Successor Agent's telephone number _____

My Successor Agent has the same powers and rights as my Agent. Each individual identified as my Agent is, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), as amended, my personal representative for all purposes related to any assessment of my capacity to make informed decisions regarding my health care.

2. Effectiveness. This Power of Attorney will be effective only if I become disabled as determined by applicable law or I am unable to speak for myself. My Agent's powers are suspended for any period during which I recover from my disability or I am able to speak for myself.

3. Powers of Agent. My Agent has full authority regarding all health care and medical treatment decisions, including mental health care, to be made for me. Generally, I intend for my Agent to have the same authority to exercise my rights of liberty and self-determination that I have while I am competent. My Agent must follow my expressed wishes, either written or oral, regarding my medical treatment. In making any decision, my Agent should first try to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, based on my written or oral statements, then my Agent shall choose for me based on what my Agent believes to be in my best interests. These powers include without limitation the following:

a. **Provide for Residential Care.** To authorize (even against medical advice) my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

b. **Access to Medical Records.** To have full access to any information regarding my physical or mental health, including medical and hospital records. This includes access to protected medical information as defined under HIPPA and any applicable regulations. I waive all privileges that may apply to such information and records in order to make them available to my Agent.

c. **Employ Health Care Personnel.** To hire and fire physicians, psychiatrists, dentists, nurses, therapists, emergency personnel and any other health care providers.

d. Give and Withhold Consent to Medical Treatment. To give, withhold, modify and revoke consent to all types of medical care, procedures, tests and treatments and the administration or withdrawal of drugs.

e. Refuse Treatment. To refuse medical treatment and sign any waivers or releases from liability required by a hospital, physician or other medical personnel to implement my wishes.

f. Relief of Pain. To order whatever is appropriate to keep me as comfortable and free of pain as is reasonably possible, including the administration of pain-relieving drugs, surgical or medical procedures calculated to relieve my pain, as well as unconventional pain-relief therapies which my Agent believes may be helpful.

g. Psychiatric Guardian. To act as my psychiatric guardian with regard to any psychiatric medical care or treatment for me.

h. Contract Liability. To contract on my behalf for any health care related service or facility, without my Agent incurring personal financial liability for such contracts.

i. Enforcement. To pursue legal action, including a request for damages, on my behalf against any individual or entity that fails to recognize this document.

4. Third-Party Reliance. Any person who relies in good faith on the authority of my Agent under this document prior to actual knowledge that this Power of Attorney has been revoked or terminated will not incur any liability to me, my estate or my heirs, successors or assigns. My Agent's signature under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent and acting on my own behalf.

5. Statement of Health Care Desires.

a. Specific instructions regarding care I do want:

_____

_____

_____

b. Specific instructions regarding care I do not want (specific types of treatment that are inconsistent with religious beliefs of unacceptable for any other reason, such as blood transfusion, electroconvulsive therapy or amputation):

_____

_____

_____

6. Nomination of Conservator. If a court must appoint a conservator of my person, I nominate the Agent designated in this document to serve without bond or security. If that Agent is not willing, able or reasonably available to act as conservator, I nominate the alternate Agent whom I have named to serve without bond or security.

7. Miscellaneous Provisions.

a. Reimbursement of Costs. My Agent is entitled to reimbursement for all reasonable costs and expenses actually incurred and paid by my Agent on my behalf. However, my Agent is not entitled to compensation for his/her services.

b. Durable Power. This is a durable Power of Attorney and shall not be affected by my disability or incapacity.

c. Revocation and Amendment. I revoke any prior Health Care Power of Attorney that I may have executed and I retain the right to revoke or amend this document.

d. Original Counterparts. Photocopies of this signed Power of Attorney shall be treated as original counterparts.

e. No Bond Required. My Agent is not obligated to furnish bond or other security.

f. Governing Law. This power of attorney shall be interpreted and construed in accordance with the laws of the State of Nebraska. However, I intend for this durable power of attorney to be honored in any jurisdiction where it is presented and for such jurisdiction to refer to Nebraska law to interpret and determine the validity and enforceability of this document.

g. Severability. If any power or authority granted to my Agent is invalid or unenforceable for any reason, the other powers and authority given to my Agent will remain in full force and effect.

I have read this Power of Attorney for Health Care. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this Power of Attorney for Health Care at any time by notifying my attorney in fact, my physician, or the facility in which I am a patient or resident. I also understand that I can require in this Power of Attorney for Health Care that the fact of my incapacity in the future be confirmed by a second physician.

Signature _____Date _____

Declaration of Witnesses

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witness signature_____Date _____

Witness printed name _____

Address _____

Witness signature_____Date _____

Witness printed name _____

Address _____

State of Nebraska, County of _____

On this date of _____, before me _____, a notary public

in and for _____County, personally came _____

to me, known to be the identical person whose name is affixed to the above Power of Attorney for Health Care as principal and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledge the execution of the same to be his or her voluntary act and deed and that I am not the attorney in fact or successor attorney in fact designated by this Power of attorney for Health Care.

Witness my hand and notarial seal at _____in such county the day and year last above written.

_____ Notary Public signature

_____ Commission expiration

Copies of this Power of Attorney for Health Care have been given to:_____

State of Nebraska
Rights of the Terminally Ill Act
Declaration

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Ace, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Signed, this _____ day of _____,20_____

Signature _____

Address_____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address _____

Witness _____

Address _____

OR, the declarant voluntarily signed this writing in my presence.

Notary Public _____

Copies of this directive have been given to:_____